Let the Savings Begin!

Enrollment is easy. Just fill out the form below and mail it to:

Monroe County Prescription Discount Plan
P.O. Box 25415
Rochester, NY 14625-0415

CARDHOLDER INFORMATION

CAREFULLY PRINT ALL INFORMATION

Last Name: First Name: MI:

Employer or Association Name: **Monroe County**

Date of Birth (mm-dd-yyyy): Social Security Number:

County of Residence: Gender (circle one): Male Female

Street Address:

Mailing Address (if different from street address):

City: State: Zip Code:

E-mail (optional):

Telephone:

Membership cards will be mailed to the mailing address listed above.

SECONDARY CARDHOLDER

CAREFULLY PRINT ALL INFORMATION

Last Name: First Name: MI:

Employer or Association Name: **Monroe County**

Date of Birth (mm-dd-yyyy): Social Security Number:

County of Residence: Gender (circle one): Male Female

PRIMARY CARDHOLDER SIGNATURE

Signature: Date: